

THE 2010 ANNUAL HOSPITAL QUESTIONNAIRE

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2010 ANNUAL HOSPITAL QUESTIONNAIRE

METHODOLOGY

The Annual Hospital Questionnaire (AHQ) is administered by the Division of Health Systems Development, Office of Policy, Planning and Statistics, of the Illinois Department of Public Health (IDPH) under the authority of the Illinois Health Facilities and Services Review Board (IHFSRB) [Planning Act 20 ILCS 3960/]. It is self reported hospital data and is the responsibility of hospital management to assure the accuracy of the data submitted. IDPH verifies the data and strives for accuracy and completeness of the report before they are published. The data is published in the form of the “Annual Hospital Profiles”, and posted for public viewing and usage.

URL: http://www.hfsrb.illinois.gov/HospProf_ABR.htm

Overview and Time Frame

The questionnaire is administered electronically to all hospitals in the State of Illinois. The completed data, along with signature verification, are submitted electronically to IDPH. Signature of the Chief Executive Officer (CEO) of the facility attesting to the best of his or her knowledge that “...data contained in the questionnaire are true and accurate” is mandatory for the data to consider complete. This year too similar to last year the signature page was part of the questionnaire. By checking the box on the last page, the officer of each facility attested to the validity of the data being submitted. This differed from previous years in submittal of hard-copy attestation.

Email contacts were tested prior to the original transmission of the survey. On February 17, 2011 the AHQ was distributed electronically to all 215 hospitals as a formal request for information, with a due date of March 31, 2011. An email reminder was sent to all hospitals a week before the survey was due. For each facility failing to submit by the due date, a certified letter requesting completion and submission of the questionnaire to IDPH by April 29, 2011 was mailed to the administrator on April 8, 2011. This year too, with the cooperation of the Illinois Hospital Association (IHA), all hospitals were requested to validate their data submittal. On June 13, 2011 IDPH sent a copy of the rough profile to each hospital administrator via certified mail. This provided each respondent a chance to look at the data submitted and an opportunity to correct the data if necessary. IDPH requested that hospitals submit corrections via email with a return date of July 8, 2011.

Several errors were identified by hospital representatives and corrected data was entered into the profiles by IDPH staff.

Differences from Previous AHQs to 2010 AHQ

1. This year the timeframe to complete the questionnaire was 45 days compared to 60 days in previous years' questionnaires.
2. Both the ABR and AHQ were administered at the same time with the same turnaround time (due date).
3. The choice on "management of the facility" has been organized. Choices for facility "certification" and "designation" have been modified.
4. Charity care question on the "number of patients" and the "Amount of charity care services provided at cost" has been clarified.
5. Primary payor has been defined clearly for the purposes of inclusion in patient volume. Financial data were requested to be derived from the respondents' most recent audited financial statements or review or compilation of the financial statements or tax return for the most recent fiscal year available to them. Questionnaire has 2 parts. **Part I is collected based on the calendar year, whereas the financial Part II is based on the individual facility's fiscal year.**
6. Diagnostic as well as Interventional Angiography Equipment and its utilization has been included in the Imaging section of the survey.
7. Utilization of Linear Accelerators including Image Guided Radiation Therapy (IGRT) and Intensity Modulated Radiation Therapy (IMRT) were requested. Treatments performed on the machine have been requested unlike the courses of treatments as required in previous years.
Please note: Linear Accelerators utilization reported for 2010 will be lot higher than previous years.
8. Questions on Infection control and Prevention has been added, however that is not reflected on the profile currently.

With the co-operation of the Illinois Hospital Association (IHA), all hospitals were requested to validate these data after initial submittal.

Validation and Compilation of 2010 AHQ data

The survey data submitted by each facility is received by the IDPH server and exported into the database. The key fields validated when the survey is submitted are as follows:

- Peak beds set up and staffed exceeding the (authorized bed) CON limit;
- Quality checks on the occupancy rate and payor source parameters;
- Average length of stay (ALOS), occupancy rates and average daily census (ADC) exceeding 100% capacity;
- Cardiac catheterization data (lab and utilization) as compared to data submitted in previous years; expected to be similar or indicate gradual increase/decrease;
- Cardiac Catheterization utilization is limited to Cardiac (coronary) procedures only and will not include any peripheral, renal or thoracic cath procedures, although we ask for total cath labs (physical set up) and may perform non-coronary cath procedures in those labs.
- Race-ethnic data matching the utilization admission and patient days;
- Outpatient and Inpatient surgical time per case tested to the state average;

- Trauma and ER data is verified if a facility does have a trauma and ER center.
- Number of patients listed under payor source category (inclusive of the charity care) validated to admissions to the facility in that calendar year.
- Linear Accelerator machine usage (Treatments Vs Treatment courses) was requested by the facilities although on the 2010 survey instrument Treatment courses (number of patients served) was listed.

Hospitals were given a chance to correct their data to avoid declaratory ruling requests after the data is published. The time frame for hospitals to correct data ended July 8, 2011. IDPH staff has made every effort to contact the respective facilities to verify the data submitted and an opportunity was given to correct the data if errors were detected. Ultimately, management in each hospital is responsible for assuring and ensuring the accuracy and completeness of the data submitted by the hospital.

NOTE:

In 2010, Kindred Hospital - Springfield started its services. Larabida and Shriners' hospitals had CON beds (Authorized beds) reclassified; M/S beds to Pediatric category of service to reflect the practical utilization of their facility.

Questions may be addressed to:

Data Section

Division of Health Systems Development

525 W. Jefferson St., 2nd Floor

Springfield, IL 62761

Or email: DPH.FacilitySurvey@illinois.gov

Welcome to the
ILLINOIS DEPARTMENT OF PUBLIC HEALTH (IDPH)
ANNUAL HOSPITAL QUESTIONNAIRE FOR CALENDAR YEAR 2010

This is a formal request by IDPH for full, complete and accurate information as stated herein. This request is made under the authority of the Health Facilities Planning Act [20 ILCS 3960]. Failure to respond may result in sanctions including the following:

"A person subject to this Act who fails to provide information requested by the State Board or State Agency within 30 days of a formal written request shall be fined an amount not to exceed \$1,000 for each 30-day period, or fraction thereof, that the information is not received by the State Board or State Agency." [20 ILCS 3960/14.1(b)(6)]

PLEASE NOTE

This questionnaire is divided into 2 sections.

Part I

Collects information on your facility and facility utilization.
This part **MUST BE REPORTED FOR CALENDAR YEAR 2010.**

Part II

Collects Financial and Capital Expenditure information for your facility.
This part **MUST BE REPORTED FOR THE MOST RECENT FISCAL YEAR AVAILABLE TO YOU.**

This survey must be completed and submitted by March 31, 2011.

Facilities failing to submit this questionnaire within the required time frame will be reported to the State Board for the State Board's consideration of imposition of sanctions mandated by the Act.

If you have problems or questions concerning the survey, please check the [help] links provided.

If you still have problems, contact this office via e-mail at DPH.FacilitySurvey@illinois.gov, or by telephone at 217-782-3516.

Click the button marked 'Next' at the bottom of this page to begin the survey.

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SURVEY INSTRUCTIONS

NOTE: Validation rules have been set up for some items; if your responses do not meet the validation rules, or if you have not filled in some required fields, you will not be allowed to proceed to the next page.

There are 3 buttons at the bottom of each survey page:

'Next' takes you to the the next page of the survey.

'Back' returns you to the previous survey page.

'Save' saves work in progress if you need to stop before finishing.

YOU DO NOT NEED TO SAVE AFTER EACH PAGE.

ONLY SAVE THE FORM IF YOU NEED TO STOP BEFORE COMPLETING.

IMPORTANT

When you save your work, the unfinished survey is stored on our server with a new, random address. You will be prompted to set a bookmark or Favorite in your web browser. **YOU MUST DO THIS ONLY ONCE; YOU CANNOT ACCESS YOUR SAVED FORM WITHOUT IT.** The link provided in your e-mail notice **WILL NOT** access the saved form, only a blank survey. When you are ready to continue, use the bookmark or favorite to open the form. You will be returned to the place where you left off.

The information below is for REFERENCE PURPOSES ONLY.

If you have questions about any of the information listed, please contact us via e-mail or telephone:

E-mail: DPH.FacilitySurvey@illinois.gov

Telephone: 217-782-3516

Hospital Name

Hospital Address

Hospital City

State

Zip Code

Authorized Hospital Bed Capacity (CON)

	Information
Health Service Area	<input type="text"/>
Hospital Planning Area	<input type="text"/>
County	<input type="text"/>
Approved for LTC Swing Beds?	<input type="text"/>

[\[Help\]](#)

Medical-Surgical

Pediatrics

Intensive Care

Obstetrics

Neonatal Level III

Long-Term Care

Acute Mental Illness

Rehabilitation

Long-Term Acute Care (LTACH)

December 31, 2009 December 31, 2010

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QUESTION I. INPATIENT SERVICES UTILIZATION

Report the utilization data for each category of service in the spaces below.

OBSERVATION DAYS are defined as days provided to outpatients prior to admission for the purpose of determining whether a patient requires admission as an inpatient. **OBSERVATION DAYS** = **OBSERVATION HOURS** divided by 24.**PEAK BEDS SET UP AND STAFFED** is the highest number of authorized service beds available for use at any point in time in the calendar year.**PEAK CENSUS** is the highest number of inpatients in the unit at any point in time in the calendar year.**A. MEDICAL-SURGICAL UTILIZATION:**If you have an authorized Pediatrics unit, report utilization on line B below, not on line A1.

	Admissions	Inpatient Days	Beds Set Up and Staffed on Oct. 1, 2010	Peak Beds Set Up and Staffed	Peak Census	Observation Days in Medical-Surgical Nursing Unit
A1. Medical-Surgical 0-14 years	0	0				
A2. Medical-Surgical 15-44 years	0	0				
A3. Medical-Surgical 45-64 years	0	0				
A4. Medical-Surgical 65-74 years	0	0				
A5. Medical-Surgical 75 +	0	0				
A6. Medical-Surgical Totals	0	0	0	0	0	0

B. PEDIATRIC UTILIZATION: Pediatric care is defined as non-intensive Medical-Surgical care for patients aged 0-14 years.If this service is provided in an AUTHORIZED Pediatric Unit, the data is to be recorded in this section on line B.If there is no AUTHORIZED Pediatric Unit, report Medical Surgical care for 0-14 year olds on line A1.

	Admissions	Inpatient Days	Beds Set Up and Staffed on Oct. 1, 2010	Peak Beds Set Up and Staffed	Peak Census	Observation Days in Pediatric Nursing Unit
B. Pediatric Utilization	0	0	0	0	0	0

C. INTENSIVE CARE UTILIZATION: In this section, report the utilization of your Intensive Care unit, if you have one.**Neonatal Level III (Neonatal Intensive Care) is not to be reported here.****Intermediate care units are components of Medical-Surgical care and should be included in section A.**

If an inpatient is sent directly to ICU upon admission to the hospital, report the patient in line C1; if an inpatient is admitted to another unit of the hospital and subsequently moved into ICU, report ICU utilization for that inpatient on line C2.

	Admissions	Inpatient Days	Beds Set Up and Staffed on Oct. 1, 2010	Peak Beds Set Up and Staffed	Peak Census	Observation Days in ICU Nursing Unit
C1. Inpatients Admitted Directly to ICU	0	0				
C2. Patients Transferred to ICU from another Unit of the Hospital	0	0				
C3. TOTAL ICU UTILIZATION	0	0	0	0	0	0

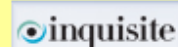
D. OBSTETRIC/GYNECOLOGY UTILIZATION: Obstetrics care includes both Ante-Partum and Post-Partum. Clean Gynaecology is the non-maternity care.

	Admissions	Inpatient Days	Beds Set Up and Staffed on Oct. 1, 2010	Peak Beds Set Up and Staffed	Peak Census	Observation Days in OB/Gyne Nursing Unit
D1. Obstetrics Patients	0	0				
D2. Clean Gynecology Patients	0	0				
D3. Total Obstetrics/Gynecology Patients	0	0	0	0	0	0

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E. NEONATAL LEVEL III (NEONATAL INTENSIVE CARE) UTILIZATION:

	Admissions	Inpatient Days	Beds Set Up and Staffed on Oct. 1, 2010	Peak Beds Set Up and Staffed	Peak Census	Observation Days in Neonatal Level III Nursing Unit
E. Neonatal Level III [Help]	0	0	0	0	0	0

F. LONG-TERM NURSING CARE UTILIZATION:

	Admissions	Inpatient Days	Beds Set Up and Staffed on Oct. 1, 2010	Peak Beds Set Up and Staffed	Peak Census	Observation Days in Long-Term Care Nursing Unit
F. Long-Term Care (LTC) [Help]	0	0	0	0	0	0

G. LONG-TERM CARE SWING BEDS (MEDICARE-CERTIFIED) UTILIZATION:

	Admissions	Inpatient Days	Peak Census
G. LTC Swing Beds (Medicare-certified) [Help]	0	0	0

H. ACUTE MENTAL ILLNESS UTILIZATION:

	Admissions	Inpatient Days	Beds Set Up and Staffed on Oct. 1, 2010	Peak Beds Set Up and Staffed	Peak Census	Observation Days in Acute Mental Illness Nursing Unit
H. Acute Mental Illness [Help]	0	0	0	0	0	0

I. REHABILITATION UTILIZATION:

	Admissions	Inpatient Days	Beds Set Up and Staffed on Oct. 1, 2010	Peak Beds Set Up and Staffed	Peak Census	Observation Days in Rehabilitation Nursing Unit
I. Rehabilitation [Help]	0	0	0	0	0	0

J. LONG-TERM ACUTE CARE UTILIZATION:

	Admissions	Inpatient Days	Beds Set Up and Staffed on Oct. 1, 2010	Peak Beds Set Up and Staffed	Peak Census	Observation Days in Rehabilitation Nursing Unit
J. Long-Term Acute Care (LTACH) [Help]	0	0	0	0	0	0

K. OBSERVATION DAYS OUTSIDE A NURSING UNIT:

If patient observation prior to admission takes place in dedicated observation beds or stations (not occurring in inpatient nursing units listed in A through I), report the number of dedicated observations beds or stations and the number of observation days here:

	Dedicated Observation Beds or Stations	Observation Days in Dedicated Observation Beds or Stations
K. Dedicated Observation Beds or Stations	0	0

FACILITY TOTAL UTILIZATION:

Report the Total Hospital Utilization Statistics in the spaces provided. TOTALS MUST INCLUDE ALL AUTHORIZED HOSPITAL SERVICES. The sub-totals reported below must equal the sum of the categories of service figures on Lines A6, B, C3, D3, E, F, G, H, I, J and K. Total Utilization is the same as on the Sub-Total line, except Intensive Care Transfers (line C2) are deducted from Admissions.

	Total Admissions	Total Inpatient Days	Total Beds Set Up and Staffed on Oct. 1, 2010	Total Observation Days in Hospital
SUB-TOTAL OF ITEMS A - K	0	0	0	0
Minus ICU Transfers from C2	0			
L. TOTAL HOSPITAL UTILIZATION	0	0	0	0

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L. INPATIENT UTILIZATION BY RACIAL GROUP AND ETHNICITY:

Report the number of Inpatients admitted to the hospital and the number of Patient Days of Care provided to Inpatients by the hospital during Calendar Year 2010 by the Racial Group and Ethnicity of the patient.

TOTAL ADMISSIONS AND INPATIENT DAYS IN SECTION 1 as well as in SECTION 2 (not a combination) MUST AGREE WITH THE FIGURES REPORTED ON LINE L, PAGE 4.

SECTION 1. RACIAL GROUPS	Inpatients Admitted	Patient Days
Asian	0	0
American Indian or Native Alaskan	0	0
Black or African American	0	0
Native Hawaiian or Pacific Islander	0	0
White	0	0
Unknown	0	0
TOTALS - SECTION 1	0	0

SECTION 2. ETHNIC GROUPS	Inpatients Admitted	Patient Days
Hispanic or Latino	0	0
Not Hispanic or Latino	0	0
Unknown	0	0
TOTALS - SECTION 2	0	0

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Question II. FACILITY OWNERSHIP AND ADMINISTRATION:

A. Legal Entity that operates the facility [\[Help\]](#)B. Legal Entity that owns the physical plant [\[Help\]](#)

C. Indicate the type of organization managing the facility (MARK ONLY ONE SELECTION):

FOR PROFIT

GOVERNMENTAL

NOT FOR PROFIT

- | | | |
|--|--|---|
| <input type="radio"/> For Profit Corporation | <input type="radio"/> County | <input type="radio"/> Church-Related |
| <input type="radio"/> Limited Partnership | <input type="radio"/> City | <input type="radio"/> Not for Profit Corporation (Not Church-Related) |
| <input type="radio"/> Limited Liability Partnership | <input type="radio"/> Township | <input type="radio"/> Other Not For Profit (specify below) |
| <input type="radio"/> Limited Liability Company | <input type="radio"/> Hospital District | |
| <input type="radio"/> Other For Profit (specify below) | <input type="radio"/> Other Governmental (specify below) | |

Other Ownership Type

D. Indicate any contracts for management of services: List any contractors who manage the selected services performed in the hospital.

Contract Management

Psychiatric Service

Rehabilitation Service

Emergency Service

E. Is your ENTIRE facility CERTIFIED by the Center for Medicare and Medicaid Services (CMS) as either of the following? (Check to indicate certification)

- | |
|---|
| <input type="checkbox"/> Critical Access Hospital |
| <input type="checkbox"/> LongTerm Acute Care Hospital (LTACH) |

F. Is your ENTIRE facility characterized as any of the following? (Check if applicable)

- | |
|--|
| <input type="checkbox"/> General Hospital |
| <input type="checkbox"/> Rehabilitation Hospital |
| <input type="checkbox"/> Children's Speciality Care Hospital |
| <input type="checkbox"/> Psychiatric Hospital |

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Question III. SURGICAL PROCEDURES - O.R. (Class C):

Record times in HOURS. Round ALL reported times UP to the next full hour. For example: 1927 minutes of surgery divided by 60 = 32.11 hours, rounds up to 33 hours. Hours of surgery are ACTUAL hours, not SCHEDULED hours.

OPERATING ROOM (CLASS C): Operating Room is defined as a setting designed and equipped for major surgical procedures that require general or regional block anesthesia and support of vital bodily functions.

(Source: Guidelines for Optimal Ambulatory Surgical Care and Office-based Surgery, third edition, American College of Surgeons)

'COMBINED' O.R.s are operating rooms used for BOTH inpatient and outpatient surgeries, NOT the sum of inpatient and outpatient operating rooms.

CASE is defined as a patient encountered in an inpatient or outpatient setting. For example, if 3 surgical procedures are performed on an individual, only 1 CASE is counted.

SURGICAL HOURS include the time to perform the surgical procedure plus time for set-up and clean-up of the operating room.

	OPERATING ROOMS (CLASS C)				SURGICAL CASES TREATED		SURGICAL HOURS		
	Inpatient	Outpatient	Combined	TOTAL	Inpatient	Outpatient	Inpatient	Outpatient	TOTAL
Cardiovascular	0	0	0	0	0	0	0	0	0
Dermatology	0	0	0	0	0	0	0	0	0
General Surgery	0	0	0	0	0	0	0	0	0
Gastroenterology	0	0	0	0	0	0	0	0	0
Neurology	0	0	0	0	0	0	0	0	0
OB/Gynecology	0	0	0	0	0	0	0	0	0
Oral/Maxillofacial	0	0	0	0	0	0	0	0	0
Ophthalmology	0	0	0	0	0	0	0	0	0
Orthopedic	0	0	0	0	0	0	0	0	0
Otolaryngology	0	0	0	0	0	0	0	0	0
Plastic Surgery	0	0	0	0	0	0	0	0	0
Podiatry	0	0	0	0	0	0	0	0	0
Thoracic	0	0	0	0	0	0	0	0	0
Urology	0	0	0	0	0	0	0	0	0
TOTAL SURGERIES	0	0	0	0	0	0	0	0	0

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Question IIIA. SURGICAL PROCEDURES - Invasive, Non OR**DEDICATED SURGICAL PROCEDURE ROOMS - Class B:**

Surgical Procedure room is defined as a setting designed and equipped for major or minor surgical procedures performed in conjunction with oral, parenteral, or intravenous sedation or under analgesic or dissociative drugs.

(Source: Guidelines for Optimal Ambulatory Surgical Care and Office-based Surgery, third edition, American College of Surgeons)

Report how many rooms your hospital has dedicated for surgical procedures not included in the table above (Question III), by Inpatient, Outpatient and Combined Inpatient/Outpatient rooms. Also report the number of Inpatients and Outpatients special procedure cases in the reporting year, and the number of surgical hours the procedures required, for both Inpatient and Outpatient procedures.

TOTAL ROOMS should be the sum of Inpatient, Outpatient and Combined rooms.

CASE is defined as a patient encountered in an inpatient or outpatient setting. For example, if 3 surgical procedures are performed on an individual, only 1 CASE is counted.

SURGICAL HOURS include the time to perform the surgical procedure plus time to set-up and clean-up the procedure room.

TOTAL SURGICAL HOURS should be the total of Inpatient and Outpatient surgical hours.

	DEDICATED PROCEDURE ROOMS				CASES		SURGICAL PROCEDURE HOURS		
	Inpatient	Outpatient	Combined	TOTAL	Inpatient	Outpatient	Inpatient	Outpatient	TOTAL
Gastro-Intestinal Procedures	0	0	0	0	0	0	0	0	0
Laser Eye Procedures	0	0	0	0	0	0	0	0	0
Pain Management Procedures	0	0	0	0	0	0	0	0	0
Cystoscopy Procedures	0	0	0	0	0	0	0	0	0

Multipurpose (Non-Dedicated) Procedure Rooms

(enter data for surgical speciality eg., Ophthalmology, General surgery, Minor procedures etc)

	0	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0	0

SURGICAL RECOVERY STATIONSStage 1 - Post-Anesthesia
Recovery StationsStage 2 - Step-down Ambulatory
Recovery Stations

How many surgical recovery stations does your hospital maintain? 0 0

Question IV. Labor, Delivery and Recovery/Newborn Care:

a. Number of Labor Rooms 0 b. Number of Delivery Rooms 0 c. Number of Birthing Rooms 0

d. Labor-Delivery-Recovery (LDR) Rooms 0 e. Labor-Delivery-Recovery-PostPartum (LDRP) Rooms 0

f. Number of Dedicated C-Section Rooms 0 g. Number of Total C-Sections Performed 0

h. Births and Newborn Care

Report the number of Total Births (Live and Stillborn), Live Births, Newborn Level I, Level II and Level II+ patient days of care, as defined by the Perinatal Advisory Committee, in the spaces provided.

	Total Births	Live Births	Newborn Level I Patient Days	Newborn Level II Patient Days	Newborn Level II+ Patient Days
Number	0	0	0	0	0

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Question V. Organ Transplantation:A. Does your hospital perform organ transplants? ☐ Yes ☐ No

	Heart	Heart/Lung	Kidney	Liver	Lung	Pancreas
B. Transplants Performed in 2010	0	0	0	0	0	0

Question VI. Cardiac Surgery (Open Heart Surgery) For definitions and information, click the [Help] link.

	Age 0-14	Age 15 and Over
a. Cardiac Surgery Cases by Age Group	0	0
b. Total Cardiac Surgery Cases (All ages)	0	
c. Of Cases in b., Number of Coronary Artery Bypass Grafts (CABGs) [Help]	0	

Question VII. Cardiac Catheterization For definitions and information, click the [Help] link.PHYSICAL SET UP:

1. Total Cardiac Catheterization labs (includes Dedicated and Non-Dedicated labs for diagnostic/Interventional/EP)
 - a. Catheterization labs dedicated to only Diagnostic procedures
 - b. Catheterization labs dedicated to only Interventional procedures
 - c. Catheterization labs dedicated to only Electro-Physiological procedures
 - d. Of the catheterization labs listed in line 1, the number shared with radiology for Angiography procedures

LABS

0
0
0
0
0

UTILIZATION (Procedures Performed by Age Group)

2. Indicate the total catheterization procedures performed including all diagnostic, interventional, and EP procedures for all age groups.

0

- a. Diagnostic Cardiac Catheterizations
- b. Interventional Cardiac Catheterizations
- c. Electro-Physiological (EP) Procedures [\[Help\]](#)

Age 0-14	Age 15 and Over
0	0
0	0
	0

Question VIII: Emergency/Trauma Care:A. Category of EMERGENCY Services :
(as defined by IL Hospital Licensing Act)☐ COMPREHENSIVE ☐ BASIC ☐ STAND BYB. Are you a designated trauma center (by Emergency Medical Services (EMS)):☐ YES ☐ NO

C. Type of the trauma center:

LEVEL 1	LEVEL 2

D. List the number of Operating rooms dedicated or reserved (24/7) for trauma:

0

E. List the number of stations in Emergency Room (ER):

0

F. Indicate the number of visits to Emergency and Trauma. Also list the number that resulted in admissions to the hospital.

	EMERGENCY (ED)	TRAUMA	TOTAL VISITS
Number of Visits	0	0	0
Admissions to Hospital (subset of visits that resulted in admission)	0	0	

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Question IX. OUTPATIENT SERVICES/VISITS:

All services or visits to all OUTPATIENT services including emergency, surgical, radiological etc provided by and billed by the hospital should be reported under outpatient visits.

A. Visits at the Hospital/Hospital Campus	<input type="text" value="0"/>
B. Visits in the facilities Off site/Off Campus	<input type="text" value="0"/>
C. TOTAL	<input type="text" value="0"/>

Question X. Patients Served during Calendar Year 2010 by Primary Payor:

Patients are to be reported by PRIMARY PAYOR - Primary Payor is the one responsible for most of the charges (generally, 50% or more). TOTAL INPATIENTS REPORTED (including Charity Care inpatients) MUST EQUAL THE NUMBER OF ADMISSIONS REPORTED ON PAGE 4, LINE L.

	MEDICARE	MEDICAID	OTHER PUBLIC*	PRIVATE INSURANCE*	PRIVATE PAYMENT*	ROW TOTALS
INPATIENTS	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
OUTPATIENTS	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>

* OTHER PUBLIC includes all forms of direct public payment EXCLUDING Medicare and Medicaid. DMH/DD and Veterans Administration funds and other public funds paid directly to a facility should be recorded here.

PRIVATE INSURANCE includes any payments made through private insurance policies.

PRIVATE PAYMENT includes money from a private account (for example, a medical Savings Account) AND any government funding made out and paid to the resident which is then transferred to the facility to pay for services.

CHARITY CARE* PATIENTS

	INPATIENTS	OUTPATIENTS
Charity Care Patients	<input type="text" value="0"/>	<input type="text" value="0"/>

****Charity care*** means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer. [20 ILCS 3960, Section 3] Charity care does not include bad debt or the unreimbursed cost of Medicare, Medicaid, and other federal, State, or local indigent health care programs, eligibility for which is based on financial need.

A Charity Care Patient is one without third-party coverage who received charity care as defined above.

Charity Care patients are not to be included in the above chart on Primary Payor.

As per AICPA guidelines, determination of charity care can be made at any time during the entire process, although it is preferred to be done when the patient presents.

Question XI. LABORATORY STUDIES:

Report the number of laboratory studies performed for BOTH inpatients (excluding newborns) and outpatients. The total number of laboratory studies are to be reported. A STUDY is defined as a billable examination, such as CBCs, lipid profiles, etc. a series of tests performed in one visit on one person is all considered to be a single study.

Many hospitals have standing contracts with one or more private laboratories to perform laboratory studies. Report the total number of laboratory studies performed under such a contract in the last column.

	Inpatient Studies	Outpatient Studies	Studies Performed Under Contract (Referrals)
Laboratory Studies Performed	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>

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Question XII. DIAGNOSTIC AND THERAPEUTIC EQUIPMENT:

A. Indicate the number of pieces of equipment your hospital had in operation on site (Fixed owned/ Fixed leased during the reporting year and the number of inpatient, outpatient and contractually-performed examinations or treatment courses performed during the reporting year.

EXAMINATIONS are to be reported - **NOT** patients served. If one patient had several examinations during the reporting year, EACH examination is counted separately. It is the the number of times a machine is used per exam/procedure or treatment course. If the hospital has a contract with an equipment supplier to provide inpatient or outpatient services on the campus of the hospital, the examinations are to be listed under exams by contractual agreement column.

PIECES OF EQUIPMENT

EXAMS/ PROCEDURES

DIAGNOSTIC/IMAGING

Hospital
Owned Contracted
(list below)

Inpatient

Outpatient

Contractual Agreement
Inpatient Outpatient

1. General Radiography/Fluoroscopy

0

0

0

0

0

0

2. Nuclear Medicine

0

0

0

0

0

0

3. Mammography

0

0

0

0

0

0

4. Ultrasound

0

0

0

0

0

0

5. CT Tomography

0

0

0

0

0

0

6. PET Tomography

0

0

0

0

0

0

7. Magnetic Resonance Imaging (MRI)

0

0

0

0

0

0

8. Angiography Equipment*

0

0

a. Diagnostic Angiography

0

0

0

0

b. Interventional Angiography

0

0

0

0

*Report Angiography Equipment on line 8, and Angiography Procedures on lines a and b.

INTERVENTIONAL & RADIATION
THERAPIESHospital
Owned Contracted
(list below)Treatment
Courses

9. Lithotripsy

0

0

0

Radiation Therapy Equipment

10. Linear Accelerators*

0

0

0

a. Image Guided Radiation
Therapy (IGRT)

0

b. Intensity Modulated Radio-
therapy (IMRT)

0

11. High Dose Brachytherapy

0

0

0

12. Proton Beam Therapy

0

0

0

13. Gamma knife

0

0

0

14. Cyber knife

0

0

0

*Report Linear Accelerators and Treatments on line 10.

Specialized use of linear accelerators for IGRT and IMRT should be reported on lines a and b.

B. List contractors for each type of equipment reported in Question XII, Part A.

If you reported any Contracted Equipment in Section A, column 3 above, list the type of equipment and the name(s) of the companies or persons with whom your hospital has contracted for equipment.

	Type of Equipment	Company/Individual Contracted With
1.		
2.		
3.		

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Question XIII. INFECTION PREVENTION AND CONTROL

Please provide the following information regarding Infection Prevention and Control staff. If a staff member fills multiple positions, use the percentage of their time that is devoted to Infection Prevention and Control, e.g., if a staff member spends 2 days a week working on Infection Control and 3 days a week working on Employee Health, only 2 days per week, or 0.4 FTE, should be counted for Infection Prevention and Control activities. Categories of employees to exclude: administrative support and data entry personnel and physician hospital epidemiologists

Infection Prevention and Control Staff	FTEs*
How many full-time equivalent staff (FTEs) were employed in your facility's infection prevention and control department, as of December 31, 2010?	<input type="text"/>
How many of the FTEs indicated in the previous question were filled by an individual who is certified in infection control (CIC), as determined by the Certification Board in Infection Control, as of December 31, 2010?	<input type="text"/>

CONTACT FOR INFECTION PREVENTION AND CONTROL INFORMATION

Please provide a contact person for information regarding Infection Prevention and Control efforts at your facility. If you have any comments pertaining to Infection Control and/or your efforts in this area, please enter them into space provided.

Name	<input type="text"/>
Telephone	<input type="text"/>
Email	<input type="text"/>
Comments	<input type="text"/>

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**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
FINANCIAL & CAPITAL EXPENDITURES DATA FOR FISCAL YEAR**

THE DATA REQUESTED BY THIS QUESTIONNAIRE ARE AUTHORIZED
PURSUANT TO THE ILLINOIS HEALTH FACILITIES PLANNING ACT [20 ILCS 3960/5.3]

THESE DOLLAR AMOUNTS MUST BE TAKEN FROM YOUR MOST RECENT ANNUAL
FINANCIAL STATEMENTS WHICH INCLUDES YOUR INCOME STATEMENT AND
BALANCE SHEET. FINANCIAL STATEMENTS ARE DEFINED AS AUDITED FINANCIAL
STATEMENTS, REVIEW OR COMPILATION of the FINANCIAL STATEMENTS, OR TAX
RETURN FOR THE MOST RECENT FISCAL YEAR AVAILABLE TO YOU.

This part of the survey collects Financial and Capital Expenditure information for your facility.
This part **MUST** be reported for the MOST RECENT FISCAL YEAR AVAILABLE to you.

If you have problems providing the information requested, contact this office via e-mail at
DPH.FacilitySurvey@illinois.gov, or by telephone at 217-782-3516.

INDICATE THE STARTING AND ENDING DATES
OF YOUR MOST RECENT FISCAL YEAR (mm/dd/yyyy)

Starting

Ending

Source of Financial Data Used

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ILLINOIS HEALTH FACILITIES PLANNING BOARD
FINANCIAL & CAPITAL EXPENDITURES DATA FOR FISCAL YEAR

1. CAPITAL EXPENDITURES

Provide the following information for all projects / capital expenditures **IN EXCESS OF \$293,500** obligated by or on behalf of the health care facility for your reported FISCAL YEAR (click the link below the table for definitions of terms):

	Description of Project / Capital Expenditure	Amount Obligated (\$)	Method of Financing	CON Project Number (if reviewed)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				

[\[Help\]](#)


Report the TOTAL of ALL Capital Expenditures for your reported FISCAL YEAR

TOTAL CAPITAL EXPENDITURES FOR REPORTED FISCAL YEAR
(including those below \$293,500)

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ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
FINANCIAL & CAPITAL EXPENDITURES DATA FOR FISCAL YEAR

2. INPATIENT AND OUTPATIENT NET REVENUES DURING YOUR REPORTED FISCAL YEAR BY PAYOR

	MEDICARE	MEDICAID	OTHER PUBLIC*	PRIVATE INSURANCE	PRIVATE PAYMENT*	ROW TOTALS
INPATIENT REVENUE (\$)	0	0	0	0	0	0
OUTPATIENT REVENUE (\$)	0	0	0	0	0	0

* **OTHER PUBLIC** includes all forms of direct public payment EXCLUDING Medicare and Medicaid. DMH/DD and Veterans Administration funds and other public funds paid directly to a facility should be recorded here.

PRIVATE INSURANCE includes any payments made through private insurance policies.

PRIVATE PAYMENT includes money from a private account (for example, a Medical Savings Account) AND any government funding made out and paid to the resident which is then transferred to the facility to pay for services.

3. AMOUNT OF CHARITY CARE* SERVICES PROVIDED DURING THE FISCAL YEAR

	INPATIENTS	OUTPATIENTS
Amount of Charity Care Services Provided at Cost (\$)	0	0

*****Charity care*** means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer. [20 ILCS 3960, Section 3] Charity care does not include bad debt or the unreimbursed cost of Medicare, Medicaid, and other federal, State, or local indigent health care programs, eligibility for which is based on financial need.

In reporting amount of charity care provided, the reporting entity must report the amount of charity care based on cost, not charges (per CMS 2552-96 Worksheet C, Part 1, PPS Inpatient Ratios).

As per AICPA guidelines, charity care can be determined at any time during the process.

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**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
FINANCIAL & CAPITAL EXPENDITURES DATA FOR FISCAL YEAR****4. Community Benefits:**

Report the dollar amounts spent on various community benefit programs offered by your facility to the community. All hospitals must complete these items immaterial of whether they are Non profit facilities or not.

If the data is not available for your reporting year then mark the appropriate box (Not Available) next to each item. However, every effort needs to be made to provide the requested information.

[Community Benefit Definitions](#)

- | | | |
|--|--------------------------------|--|
| a. Language Assistant Services | <input type="text" value="0"/> | Not Available <input type="checkbox"/> |
| b. Government Sponsored Indigent Health Care | <input type="text" value="0"/> | Not Available <input type="checkbox"/> |
| c. Donations | <input type="text" value="0"/> | Not Available <input type="checkbox"/> |
| d. Volunteer Services | | |
| i) Employee Volunteer Services | <input type="text" value="0"/> | Not Available <input type="checkbox"/> |
| ii) Non-Employee Volunteer Services | <input type="text" value="0"/> | Not Available <input type="checkbox"/> |
| e. Education | <input type="text" value="0"/> | Not Available <input type="checkbox"/> |
| f. Government Sponsored program services | <input type="text" value="0"/> | Not Available <input type="checkbox"/> |
| g. Research | <input type="text" value="0"/> | Not Available <input type="checkbox"/> |
| h. Subsidized health services | <input type="text" value="0"/> | Not Available <input type="checkbox"/> |
| i. Bad Debts | <input type="text" value="0"/> | Not Available <input type="checkbox"/> |
| j. Other Community Benefits | <input type="text" value="0"/> | Not Available <input type="checkbox"/> |

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Please provide the following information for the individual responsible for the preparation of this questionnaire:

Contact Person Name

Contact Person Job Title

Contact Person Telephone Number

Contact Person E-Mail Address

Please provide the following information for the facility Administrator/CEO:

Administrator's Name

Administrator's Title

Administrator's Telephone

Administrator's Email Address

If you have any comments on the survey, please enter them in the space provided below.

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CERTIFICATION OF SURVEY DATA

Pursuant to the Health Facilities Planning Act (20 ILCS 3960/13), the State Board requires "all health facilities operating in the State to provide such reasonable reports at such times and containing such information as is needed" by the Board to carry out the purposes and provisions of this Act. By completing this section, the named individual is certifying that he/she has read the foregoing document, that he/she is authorized to make this certification on behalf of this facility, and that the information contained in this report is accurate, truthful and complete to the best of his/her knowledge and belief. Please note that the State Board will be relying on the information contained in this document as being truthful and accurate information. Any misrepresentations will be considered material.

☒ I certify that the information in this report is accurate, truthful and complete to the best of my knowledge.

Person Certifying Job Title Certification Date **THANK YOU FOR COMPLETING THE ANNUAL HOSPITAL QUESTIONNAIRE**

**ONCE YOU HAVE SUBMITTED THE FORM,
NO FURTHER ACCESS OR CHANGES ARE POSSIBLE.**

**YOU CANNOT RETRACT OR CHANGE A SUBMITTED FORM, SO BE SURE TO VERIFY
YOUR ANSWERS BEFORE CLICKING ON THE 'SUBMIT FORM' BUTTON.**

**WHEN YOU HAVE REVIEWED AND VERIFIED YOUR RESPONSES, CLICK THE
'SUBMIT FORM' BUTTON TO SEND YOUR COMPLETED QUESTIONNAIRE BACK TO
OUR OFFICE. YOU WILL BE ROUTED TO A CONFIRMATION PAGE.**

**You will see an acknowledgment on the web page you are viewing.
A dated receipt is also available for printing purposes.**

**IF YOU HAVE ANY PROBLEMS, PLEASE CONTACT THIS OFFICE IMMEDIATELY AT
217-782-3516 OR BY EMAIL AT DPH.FacilitySurvey@illinois.gov**

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Term	Definition	Comments
Authorized Hospital Bed Capacity (CON)	Number of beds recognized for planning purposes at a hospital facility, as determined by HSRB and licensed by Illinois Department of Public Health.	According to Administrative rule 1100.220
Annual Admissions	Number of patients accepted/admitted for inpatient service during a 12 month period.	According to Administrative rule 1100.220
Annual Inpatient Days	"Inpatient Days" means the total number of days of service provided to inpatients in a facility over a 12-month period. Inpatient days of care are counted as beds occupied at the time the daily census is counted. Total Inpatient days is Inpatient days+ Observation days	According to Administrative Rule 1100.220
Average Length of Stay (ALOS)	Over a 12-month period the average duration of inpatient stay expressed in days as determined by dividing total inpatient days by total admissions.	According to Administrative rule 1100.220
Average Daily Census	Over a 12 month period the average number of inpatients receiving service on any given day.	According to Administrative rule 1100.220
Category of Service: a. Medical-Surgical	Assemblage of inpatient beds of M/S categories and Age groups include 15 and over usually. If a hospital has an authorized pediatric unit, then report the utilization under pediatric category. Then M/S under 0-14 category should be zero.	According to Administrative rule 1110.520. If your facility operates telemetry beds, they should be part of Med surg beds. Please note: They cannot be considered as an add-on

	<p>If the facility is not authorized for pediatric beds then the utilization should be reported under Med-Surg 0-14 years.</p>	<p>to existing Med-Surg beds that your facility is authorized for.</p>
b. Neonatal ICU (NICU)	<p>NICU is a designated Level III nursery as designed by the IL Perinatal Advisory Committee.</p> <p>NICU is designed, equipped and operated to deliver care to high risk infants identified in the neo-natal period.</p>	<p>According to Administrative code 1110.920</p> <p>According to 77 IL Administrative code 640 – Regionalized Perinatal Healthcare code.</p>
c. Obstetrics/Gynecology (OB/Gyn)	<p>OB/Gyn unit designed, equipped, organized and operated in accordance with Hospital License Act.</p> <p>i. Maternity care is subcategory of obstetric. Medical care of a patient prior to and during the act of giving birth either to a living child or a dead fetus. Provides care to both patient and newborn infant under the direction of medical personnel.</p> <p>ii. Gynecology (clean Gynecology) is deals with gynecological, surgical medical cases which are admitted to a post partum section of an obstetric (maternity) unit.</p>	<p>According to Administrative rule 1110.520</p> <p>According to Administrative rule 1110.520 subsection (b)(3)</p> <p>According to Administrative rule 1110.520 subsection (b)(5)</p>
d. Pediatric	<p>Entire facility or distinct unit of a facility which is designed, equipped, organized and operated</p>	<p>According to Administrative rule 1110.520</p>

<p>e. Intensive Care Unit</p>	<p>to provide non intensive medical surgical care to 0-14 years of age.</p> <p>Designed, equipped, organized and operated to deliver optimal medical care for critically ill. Includes all age groups. The Intensive Care category of service includes sub categories Like MICU, SICU, CCU, PICU etc.</p>	<p>According to Administrative rule 1110.520</p> <p>Burn beds are part of intensive care unit and have been added to the ICU inventory (effective Feb 15, 2003)</p>
<p>f. Comprehensive Rehabilitation (Rehab)</p>	<p>Comprehensive rehabilitation is a special referral unit which is designed, equipped, organized and operated to deliver inpatient rehabilitation services.</p>	<p>According to Administrative rule 1110.620</p>
<p>g. Acute/Chronic Mental Illness (AMI)</p>	<p>Acute Mental Illness is a distinct unit in a facility designed, equipped, organized and operated to deliver inpatient and supportive acute AMI treatment services. AMI is typified by an average length of stay of 45 days or less for adults and 60 days or less for children and adolescents.</p>	<p>According to Administrative rule 1110.720</p>
<p>Cardiac Catheterization Laboratory</p>	<p>Cardiac Cath lab is a distinct lab that is staffed equipped and operated solely for the provision of dedicated or non-dedicated cardiac diagnostic, interventional and electrophysiology procedures.</p>	

<p>a. Diagnostic Cardiac Cath lab (DCC)</p> <p>b. Interventional Cardiac Cath lab (ICC)</p> <p>c. Angio or multiuse Labs</p>	<p>Labs where dedicated catheterization procedures associated with determining the blockage of blood vessels and the diagnosis of cardiac diseases that are performed</p> <p>Labs where percutaneous coronary interventional procedures are performed</p> <p>Lab that has equipment, staff, and support services required to perform other angiographic procedures.</p>	
<p>Cardiac catheterizations</p> <p>a. Diagnostic and Interventional Cardiac Catheterization</p> <p>b. Electrophysiology Studies (EPS)</p>	<p>Diagnosis and/or treatment of cardiac diseases associated with the blockage or narrowing of the blood vessels and diseases of the heart</p> <p>Cardiovascular interventions include but not limited to Percutaneous Transluminal Coronary Angioplasty (PTCA), rotational atherectomy, directional atherectomy, extraction atherectomy, laser angioplasty, implantation of intracoronary stents and other catheter devices for treating coronary atherosclerosis.</p> <p>Electrophysiology studies are conducted to determine the focus of arrhythmias in the heart.</p>	<p>According to Administrative rule 1110.1320</p>

	Electrodes are placed in the heart during a cardiac catheterization, making it possible to measure the electrical potential of different locations within the heart and determine the area responsible for an arrhythmia and ability to destroy abnormal cells causing rhythm disturbances.	
Cardiac Surgery	Cardiac Surgery is surgical procedure or procedures on heart and thoracic great vessels performed on a patient during a single session in a cardiac surgery operating room including but not limited to coronary artery bypass graft, myocardial revascularization, aortic and mitral valve replacement, ventricular aneurysm repair, and pulmonary valvuloplasty All interventional cardiac procedures performed on a patient during one session in the laboratory (one patient visit equals one intervention regardless of number of procedures performed.	For purposes of this section, cardiac surgery does not include heart transplantation and diagnostic and interventional cardiac catheterization.
Charity Care	“Charity Care” is defined as care for which the provider does not expect to receive payment from the patient or a third party payor. Charity care does not include bad debt or the unreimbursed cost of	CMS 2552-96 Worksheet C, Part 1 PPS

	real time moving of internal structures.	cardiogram) etc areas often.
b. Nuclear Medicine	Branch of medical imaging that uses radioisotopes (radionuclide's) in the disease diagnosis	According to American College of Radiologists (ACR)
c. Ultrasound	Is a diagnostic medical imaging technique using high frequency sound waves to get visual images of internal organs. Unlike X-rays these do not involve exposure to radiation	
d. CT Tomography	It is also a non-invasive medical imaging employing tomography. It is of much use in bodily structures based on their ability to block Rontgen/X-ray beams.	
e. PET Tomography	Positron Emission Tomography is a nuclear medicine imaging technique producing 3 D images of functional processes in the body. The system detects pairs of gamma rays emitted indirectly by a positron-emitting radionuclide (tracer), which is introduced into the body.	
f. Mammography	Is a diagnostic procedure/ exam in which low dose amplitude –X rays are utilized to examine the human breast.	

<p>g. Magnetic Resonance Imaging (MRI)</p> <p>h. Angiography</p>	<p>Non-invasive medical imaging technique used in radiology to visualize the structure and function of the body. Has much greater precision than CT on soft tissues. Hence offers greater uses in Neurology and Oncology. MRI uses magnetic fields and not ionizing radiation</p> <p>Angiography could be both a diagnostic as well as an interventional procedure. It is inclusive of but not limited to x-rays with catheters computed tomography (CTA) and Magnetic Resonance (MRA)</p>	<p>American College of Cardiology/Society for Cardiac Angiography and Interventions</p>
<p>Laboratory Studies</p> <p>a. Inpatient Studies</p> <p>b. Outpatient Studies</p> <p>c. Studies performed under</p>	<p>A study is defined as billable examination. A series of related tests performed in one visit on a person is considered as one study.</p> <p>Inpatient lab studies done on inpatients except for newborns. Newborns are not patients admitted hence newborn studies are excluded.</p> <p>Outpatient lab studies are studies done patients that come into outpatient services and may include non-patients (those get tested on preventive care).</p> <p>Studies performed under</p>	

Contract (Referrals)	contract at another laboratory are termed as referral studies	
Observation Days	Number of days of service provided to outpatients for the purpose of determining whether a patient requires admission as an inpatient or other treatment. The observation period shall not exceed 48 hours. OBSERVATION DAYS = OBSERVATION HOURS divided by 24	According to Administrative Rule 1100.220
Observation Beds/stations (Dedicated)	Indicate the number of observation beds or stations if operating and available anywhere but not occurring in inpatient nursing units.	May or may not be admitted into the hospital
Observation Days in dedicated observation beds/stations outside the nursing unit	Indicate the number of days spent in those operating observation beds or stations available anywhere but within the given specific nursing unit.	May/may not be billed for observation.
Observation days in a particular nursing unit	Indicate number of beds/stations if available and operating in a given nursing unit (like Ob, ICU, and Med-surg etc) in your facility.	These beds do not count toward the Authorized Hospital Bed Capacity (CON beds). The days will be added into calculation of ALOS
Occupancy Rate	Measure of inpatient health facility use, determined by dividing average daily census by the calculated capacity. It measures average percentage of facility's beds occupied and may be institution-wide or specific for one department or service.	According to Administrative rule 1100.220

b. Stage 2	Stage 2 are used for less intensive procedures which involve less anesthesia there by need less time to recuperate.	
Outpatient Visits	All services or visits provided by physician to all outpatient services including emergency, surgical, radiological provided by and billed by the hospital.	
a. Hospital/Campus	Visits provided by physician to all outpatient services including emergency, surgical, radiological provided by and billed by the hospital and occurring at the hospital or hospital campus.	
b. Off site/off campus	Visits provided by physician to all outpatient services including emergency, surgical, radiological provided by and billed by the hospital and occurring off site/off campus.	
Peak bed set up and staffed	Maximum number of beds by category of service the facility considers appropriate to place in patient rooms taking into account patient care requirements and ability to perform the regular functions of patient care required for patients	According to Administrative rule 1100.220
Peak Census	Indicate your facility's maximum number of patients in Authorized Hospital Bed Capacity	Measures the facility's peak utilization.

	(CON Beds) at any one time during the reporting calendar year.	
Revenue by payment source	Include the amount of net revenue of the facility during the fiscal year for the inpatients and outpatients served by the payment type.	Revenue to be listed
a. Private Pay	Private pay includes money from a private account (for example, a medical savings account) and any government funding made out and paid to the resident which is then transferred to the facility to pay for services. It also includes all the Self pay payments.	
b. Other Public	Other public includes all forms of direct public payment excluding Medicare and Medicaid. DMH/DD and veterans' administration funds and other funds paid directly to a facility should be recorded here.	
Source of Financial Data Used	Indicate the source from which the financial information has been taken. The sources include audited financial statements, review or compilation of financial statements or tax return for most recent fiscal year.	The fiscal year and the source of financial data could be quite different to each hospital.
Radiation Therapy	Radiation Oncology uses ionizing radiation to control malignant/cancer	According to ACR

<p>a. Linear Accelerator</p> <p>b. Gamma Knife</p> <p>c. Lithotripsy</p> <p>d. Proton Beam Therapy</p>	<p>causing cells. Produces high velocity/energy to atomic particles in radiation therapy.</p> <p>Device used to treat brain tumors. It aims gamma radiation and contains cobalt -60.</p> <p>Lithotripsy is a non-invasive treatment course, uses high intensity, focused acoustic pulse to break Kidney and Biliary Calculi</p> <p>A beam of protons are used to radiate the tumors. However they are targeted very precisely and release most of its energy causing less damage to healthy tissue.</p>	
<p>Labor-Delivery-Recovery-Postpartum rooms</p> <p>Total Births</p> <p>Live Births</p>	<p>Rooms dedicated to complete maternity suites.</p> <p>Total number of babies born vaginally or by C-Section, including both live births and fetal deaths/stillborn. It is not number of moms being brought into delivery room. If a mother gives birth to twins, it would be two births and not one.</p> <p>"Born alive", "live born", and "live birth", when applied to homo sapiens species, each mean</p>	<p>These beds can be counted towards OB-Gyn beds</p> <p>According to American Academy of Pediatrics (College of Obstetricians and Gynecologists)</p> <p>Perinatal Advisory committee, Administrative rule title 77 IL section 640. (720 ILCS 510/2) (from Ch. 38, par. 81-22)</p> <p>According to American Academy of Pediatrics (College of Obstetricians</p>

	complete expulsion or extraction from his or her mother and after such separation breathed or showed evidence of any of the following: beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, irrespective of the duration of pregnancy and whether or not the umbilical cord has been cut or the placenta is attached..	and Gynecologists)
Trauma	Trauma – any significant injury which involves single or multiple organ systems. (Section 3.5 of the Act)	Section 3.90 of the EMS Act
a. Trauma Center	hospital with designated capabilities provides care to trauma patients; approved EMS System;	Can be Level 1 for Adult but is Level 2 for Pediatric trauma.
b. Trauma Level I	According section 515.2030, Ob/Gyn, pediatric surgery or cardiovascular surgical sub specialist must arrive within 30 minutes	Section 515.2030
c. Trauma Level II	Pursuant to Section 515.2040, essential services available in-house 24 hours per day, and to provide other essential services readily available 24 hours a day and specialist to arrive in 60 minutes	Section 515.2040
Treatment Courses	Typical course of events (procedures) that needs	

	<p>to be completed for a specific patient that undergoes radiation therapy.</p> <p>The frequency and length of a treatment course is individualized and it depends on the type of the tumor being treated.</p>	
--	--	--

Financial/Capital Expenditures Definitions:

1. **ON BEHALF OF HEALTH CARE FACILITY:** Any transactions undertaken by the facility or by any other entity other than the facility which results in constitution or modification of the facility and directly or indirectly results in the facility billing or receiving reimbursement, or in participating or assuming responsibility for the retirement of debt or the provision of any services associated with the transaction.
2. **CAPITAL EXPENDITURE:** Any expenditure : (A) made by or on behalf of a health care facilityand (B) which under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance, or is made to obtain by lease or comparable arrangement any facility or part there of or any equipment for a facility or part... and includes the cost of any studies, surveys, designs, plans, working drawings, specification and other activities essential to the acquisition, improvement, expansion or replacement of any plant or equipment with respect to which an expenditure is made... and includes donations of equipment of facilities or a transfer of equipment or facilities at fair market value.
3. **CONSTRUCTION OR MODIFICATION:** The establishment, erection, building, alteration, reconstruction, modernization, improvement, extension, discontinuation, change of ownership, of or by a health care facility, or the purchase or acquisition by or through a health care facility of equipment of service for diagnostic or therapeutic purpose or for facility administration or operation, or any capital expenditures made by or on behalf of a health care facility.
4. **METHOD OF FINANCING:** The source of funds required to undertake the project or capital expenditure. Forms of financing include equity (cash and securities), lease, mortgages, general obligation bonds, revenue bonds, appropriations and gifts/donations/bequests.
5. **OBLIGATION:** The commitment of funds directly or indirectly through the execution of construction or other contracts, purchase order, lease agreements of other means for any construction or modification project.

NOTE: Funds obligated in a given year should not be carried forward to subsequent years due to phased or periodic payouts. For example, a facility signs a \$2 million contract in 2006 for construction of a new bed wing. Construction takes approximately three years with payments being made to the contractor during 2006, 2007 and

2008. The entire \$2 million would be listed once as an obligation for 2006 and would not be listed in subsequent years.

6. **PROJECT:** Any proposed construction or modification of a health care facility or any proposed acquisition of equipment undertaken by or on behalf of a health care facility regardless of whether or not the transaction required a certificate of need. Components of construction or modification, which are interdependent, must be grouped together for reporting purposes. Interdependence occurs when components of construction or modification are architecturally and/or programmatically interrelated to the extent that undertaking one of more of the components compels the other components to be undertaken. If components of construction or modification are undertaken by means of a single construction contract, those components must be grouped together. Projects involving acquisition of equipment, which are linked with construction for the provision of a service cannot be segmented. When a project or any component of a project is to be accomplished by lease, donation, gift or any other means, the fair market value or dollar value, which would have been required for purchase, construction or acquisition, is considered a capital expenditure.
7. **NET REVENUE:** Net Revenue is the result of gross revenue less provision for contractual adjustments from third party payors (Source: AICPA).
8. **COMMUNITY BENEFIT:** Report the dollar amounts spent on the different community benefit activities.

NOTE: Hospitals that are required to report community benefits to the AG, have six months from the close of their fiscal year to do so. For the IDPH Questionnaire, some hospitals may have completed a fiscal year, but have not yet completed their community benefit report. These hospitals will only have available their report from last year, please report which is all you will be able to provide, however indicate that in the comment box.

- **Language assistant services.** Unreimbursed actual costs pertaining to language assistance service such as salaries and benefits of translators, costs of translation services provided via phone and costs of forms, notices and brochures provided in languages other than English, offset by any revenue received for these services.
- **Government Sponsored Indigent Health Care.** Unreimbursed cost of Medicare, Medicaid, and other federal, State, or local indigent health care programs, eligibility for which is based on financial need. Includes both inpatient and outpatient services. In calculating this cost, hospitals should apply a total cost-to-charge ratio to obtain costs, unless the hospital has an alternative method for determining costs, then deduct any revenues that were received for such services.
- **Donations.** Cash and in-kind donations such as the value of meeting space, equipment, and personnel to assist other community health care providers, social service agencies and organizations.
- **Volunteer Services.** Voluntary activities provided by hospital employees and volunteers in connection with a hospital's Community Benefits Program that take place as the result of a formal hospital initiative to organize or promote voluntary participation in the activity. Value of volunteer time is to be calculated as the number of volunteer hours multiplied by minimum wage.
- **Education.** Costs incurred for hospital-based educational programs such as medical residency and internships and nursing, radiology technician and physical therapy programs, reduced by direct medical education funding from third-party payer reimbursement, offsite rotation revenue, fees charged, etc. Community health education and wellness programs should be reported under Subsidized Health Services section.

- **Government-sponsored program services.** Any other unreimbursed costs not included in Government Sponsored Indigent Health Care section.
- **Research.** Cost of research activities conducted primarily to advance medical or health care services, including clinical drug trials, demonstration projects for alternative delivery systems, disease-specific research, etc. This portion of the report should include only actual costs not covered by grant funding or donations.
- **Subsidized health services.** Subsidized health services for which the hospital, in response to community need, must subsidize from other revenue sources. It includes, but is not limited to, such services as emergency and trauma care, neonatal intensive care, community health clinics, and collaborative efforts with local government or private agencies to prevent illness and improve wellness, such as immunization programs. Includes specialty services that yield a financial loss such as rehabilitation, burn care, substance abuse, AIDS, geriatric, pediatric, clinics, hospice, physician referral service, ambulance and programs to prevent illness or injury and improve wellness such as community health screenings, immunization programs, health education, counseling and support groups, poison control, etc. Hospitals should determine the financial loss by calculating the costs of staff, materials, equipment, space, etc., offset by any third-party payment, patient fees, or donations.
- **Bad debts.** The bad debt expense resulting from the extension of credit for services the hospital provided for which payment was expected but not received.
- **Other Community Benefits.** Include any other community benefits that are not listed above.